ORAL STATEMENT PRESENTED MARCH 3, 2010 BY MAINE REP. SHARON TREAT ON BEHALF OF THE MAINE CITIZEN TRADE POLICY COMMISSION

Good afternoon. I am Sharon Treat, a Maine State Representative and a member of the Maine Citizen Trade Policy Commission (CTPC or Commission). I am here today representing the co-chairs of the Commission, Senator Troy Jackson and Representative Peggy Rotundo, and the entire CTPC which voted has unanimously to testify at this hearing and to oppose the recent and disturbing expansion of the Special 301 report into the realm of disciplining countries for implementing effective and non-discriminatory pharmaceutical pricing policies.

The Maine Citizen Trade Policy Commission was established by the Maine Legislature in 2003 to assess and monitor the legal and economic impacts of trade agreements on state and local laws, working conditions and the business environment; to provide a mechanism for citizens and Legislators to voice their concerns and recommendations; and to make policy recommendations designed to protect Maine's jobs, business environment and laws from any negative impact of trade agreements. We are bipartisan and have membership representing the Maine House of Representatives and Senate, the Maine International Trade Center, various state agencies, and citizen constituencies including small businesses, manufacturers, labor, environmental organizations, and small farmers.

Our membership is determined by statute and includes a health professional. We have since our inception included a focus on health policy and trade, including pharmaceutical policy and in particular, the impact of that policy on Medicaid implementation and costs in the State. We have previously written to the U.S. Trade Representative concerning carving out Medicaid from free trade agreement provisions relating to pharmaceuticals.

Legislative members of the Commission have also met with USTR staff on these issues, and we were gratified that the Korea FTA included a footnote recognizing the role of the states implementing and paying for Medicaid and explicitly carving out these state programs.

Despite this past advocacy and the at least tacit recognition by the USTR that when trade agreements address pharmaceutical policy, there can be unintended and deleterious consequences for state health policy and access, it appears that the USTR has nevertheless embarked on an even broader effort to promote a new international trade framework to restrict ***domestic*** regulatory responses to excessive pricing by monopoly pharmaceutical suppliers.

This new direction concerns us greatly, because it will increase state health care costs and reduce access to affordable health care at the very time the Administration is pushing for universal health coverage in partnership with the States.

- **Maine relies on evidence-based reimbursement decisions to restrain pharmaceutical prices.** Like other U.S. states, Maine uses a wide variety of regulatory tools and policies to control excessive pricing by medicine suppliers. These are often the same tools used by foreign governments that USTR lists as "unreasonable" under Special 301 and has sought to restrict or eliminate in recent trade agreements. One of the most important of these state mechanisms is the Preferred Drug Lists (PDLs) in the Medicaid program.

- **Use of PDLs by Maine and other U.S. states has resulted in tremendous savings; eliminating or restricting this tool will have serious negative repercussions.** The prices paid by the State of Maine for prescription drugs in its Medicaid program average around 50% of the "Average Wholesale Price" (AWP) as a result of the federal Medicaid rebate, additional discounts through the state's supplemental rebate program, and a tiered PDL. The state also has improved its bargaining power while maintaining this basic approach by expanding the size of its purchasing pool. *At a time when brand-name drug prices and spending has increased in the double digits over a decade, Maine has been able to keep its drug spend relatively flat.*

- **Maine's approach to drug pricing is consistent with the approach taken in the majority of states, at least 40 of which rely on PDLs to bring drug prices down.** Indeed, the President's budget for 2008 specifically noted that

Medicaid "allows states to use [such] private sector management techniques to leverage greater discounts through negotiations with drug manufacturers."

- **Maine is already facing budget cuts resulting from revenue shortfalls caused by the ongoing worldwide recession – cuts that will take spending back to 2004 levels and hit health care funding especially hard.** The current Supplemental Budget as proposed by Governor John E. Baldacci would cut back on pharmaceutical access programs such as Drugs for the Elderly, a program initiated in the early 1970's – the first such program in the Nation – in an effort to balance the budget in light of reduced revenues. Any measure that increases the prices we pay now for prescription drugs would further devastate our budget and cause untold harm by cutting access to medicines.

- **The Maine Citizen Trade Policy Commission opposes USTR's promotion of international restrictions on domestic pharmaceutical pricing programs.** As noted above, we are concerned that the USTR is using trade agreements and pressure, including through Special 301, to push for the international regulation of ***domestic*** pharmaceutical reimbursement programs. In several submissions to USTR and Congress we have warned that U.S. states already use the same tools that USTR was attempting to restrict abroad. The Korea agreement included a radical provision appearing to allow industry appeals of government pharmaceutical reimbursement decisions on whether they adequately respected the "value" of patented pharmaceutical products. Such provisions, if applied to state pharmaceutical pricing programs, would significantly hamper the operation of important public health programs.

  The 2009 Special 301 Report contains additional evidence of USTR's shift of its negotiating priorities into the arena of restricting evidence-based pricing. The Report singles out Japan, Canada, France, Germany, New Zealand, Taiwan and Poland for administering "unreasonable . . . reference pricing or other potentially unfair reimbursement policies." The Report further states that:

  > The United States also is seeking to establish or continue dialogues with Organization for Economic Cooperation and

Development (OECD) members and other developed economies to address concerns and encourage a common understanding on questions related to innovation in the pharmaceutical sector.

It appears to the Commission that USTR is targeting the same policies that it has in the past – i.e. innovative reimbursement policies that effectively restrain medicine pricing in a manner similar to state preferred drug lists and other public policies. ***We oppose this use of Special 301. The U.S. should not be negotiating to limit programs abroad that are the best practices in the health care field here at home.***

- **Finally, we are concerned that the actions of USTR threaten best practices needed for health reform.** Maine has been a leader in expanding access to health care for its residents and identifying and implementing best practices to rein in excessive medical cost and promote public health. In addition to our early adoption of PDLs to expand access to medicines and implementation of pharmaceutical discount programs including Drugs for the Elderly and MaineRx Plus, Maine has pioneered initiatives including the public-private Dirigo Choice insurance product, the Maine Quality Forum, increased transparency of medical pricing and quality (including a first-in-nation web-based disclosure) and the Advisory Council on Health Systems Development which just issued a draft report on payment reform.

  Pharmaceutical policy in the U.S. is a major component of health policy – and costs – and is no less in need of reform. We spend more on pharmaceuticals than any other country in the world. Maine and other U.S. states are effectively using policies to reduce costs and promote public health by influencing prescribing decisions with evidence. As the Federal government continues working on health reform, we strongly urge that it learn from these examples, and not allow its USTR to negotiate them out of existence.